Clark County
Regional Support Network

CREDENTIALING APPLICATION

I. Provider Profile

A. Provider Information:

- Provider Name: _____
- Executive Director: _____
- Telephone: _____ Fax: _____ Email: _____
- Provider Federal Tax Identification #: _____
- CHMC License #: _____ Exp. Date: _____

Primary Office Address Attach any additional information sheets to this form	**Secondary Office Address**	**Third Office Address**
Address:		
City/St/Zip:		
Phone:	Phone:	Phone:
Fax:	Fax:	Fax:
Email:	Email:	Email:

B. What are your days/hours of operation? _____

_____

C. What arrangements do you have to provide services to Medicaid enrolled and unenrolled walk-in consumers?

_____

_____

_____

_____

_____

II. Clinical Practice Information

Please submit an updated list of clinical staff, their credentials, employment status, specialty status, and clinical specialties on the attached Practitioner Report form. This reporting format is also available electronically and may be requested through the RSN Quality Manager.

III. Practice Review (Please complete the following)

		Yes	No
A.	Within the past five years has your CMHC license ever been revoked, suspended or limited?	_____	_____
B.	Within the past five years has your clinic ever been denied professional liability insurance?	_____	_____
C.	Within the past five years has your liability insurance been refused renewal or canceled?	_____	_____
D.	Within the past five years have you had:		
	1. Disciplinary action by DSHS? (Note: For each action, please submit copy of corrective action.)	_____	_____
	2. Revocations or suspensions by: Medicare	_____	_____
	(Note: If you answered yes to either item in E, please include a copy of any current corrective action.) Medicaid	_____	_____
	3. State licensing investigations or actions?	_____	_____
	4. Malpractice suites which are pending or went to final disposition and resulted in payment to plaintiff? (Note: For each malpractice action please attach a completed liability information form.)	_____	_____
E.	All current clinicians and medical staff are in good standing with their respective state licensing body and are practicing with an unrestricted license, certification and or registration?	_____	_____

IV. Certification and Signature

I warrant that I have the authority to sign this application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. Any information entered into this application which subsequently is found to be false could result in our refusal to enter into a contract with you or termination of any contract with you.

Further I certify that this entity is compliant with all HIPAA regulations effective as of the date of this signature.

YOUR ORIGINAL SIGNATURE IS REQUIRED TO COMPLETE THIS APPLICATION.
STAMPED SIGNATURES ARE NOT ACCEPTABLE.

Signature: _____

Print Name: _____

Title: _____

Agency: _____

Date: _____

Re-credentialing Application Checklist

Please include with your application: (1) all items indicated in the comment section below (*) and/or (2) any other items that have been updated in the last year.

	ITEM	COMMENT
	ADA contact person	
	ADA Facilities Plan	
	After Hours Crisis Contact Procedures	
	Agency Complaint and Grievance Procedure	
	Audited financial statements	
	Contact person for Complaint and Grievance Procedures	
	Contact person for Information Systems	
	Critical Incident/Extraordinary Occurrence Notification Form	
	Certificates of insurance: general, professional, auto	
	Drug Free Workplace Policy	
	Inter-agency agreement with crisis services provider	
	List of formal and informal agreements with support systems indicating cross system working partnerships (i.e. schools, health district, DSHS)	
	List of staff and telephone extension numbers, including fax numbers	
	Practitioner Report form	
	MIS Quality Control Plan	
	Organizational Chart	
	Quality Management Plan	
	Sliding Fee Scale and related policies	
	Washington State Mental Health License	